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South Carolina 2015 List of Reportable Conditions

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South Carolina Law (44-29-10) and Regulations (61-20) require reporting of specified contagious and infectious diseases and conditions to the health department. In South Carolina, these diseases and conditions are specified in the List of Reportable Conditions, published annually. The list is available in printed form from DHEC’s Public Health Regional Epi Offices, and online from the DHEC website at www.scdhec.gov/Health/FHPF/ReportDiseasesAdverseEvents/ReportableConditionsInSC.



The List of Reportable Conditions specifies which illnesses are reported, within which time frames, and to where reports are to be made.



DHEC Resources for Ebola Virus Disease

Keep up with Public Health’s recommendations on preparation for and responding to the Ebola outbreak in West Africa. Additional information and archives sent via the Health Preparedness Network (HPN) are available on the DHEC Ebola webpage at: www.scdhec.gov/ebola.

Updates to the List of Reportable Conditions for 2015

New “catch-all” statement for outbreaks and other unusual events

The requirement to report “Any outbreak or unusual disease” or “Any intentional biological, chemical, or radiological event” has been replaced with “Any case that may be caused by chemical, biological, or radiological threat, novel infectious agent, or any cluster of cases, or outbreak of disease or condition that might pose a substantial risk of human morbidity or mortality.”

New Conditions Added

- **Chikungunya** has been added as urgently reportable within 24 hours. Send isolates, positive serologies, or specimens to the DHEC Bureau of Laboratories for confirmatory testing or genotyping.
- **Ciguatera** (also called Ciguatera Fish Poisoning) has been added as urgently reportable within 24 hours.
- ***Clostridium difficile*** has been added as routinely reportable, within 3 days. Reporting is required by laboratories, only. See the article on *C. diff* reporting on page 7.

Condition Removed

- **Meningoencephalitis, aseptic**, also called aseptic meningitis, has been removed from the list. This condition, which is not nationally reportable, did not have a clear case definition, and thus was inconsistently reported.

Additional Reporting Required/Clarified

- **Drug susceptibility profiles are to be reported for the following isolates:**
 - Campylobacteriosis
 - Gonorrhea
 - Influenza
 - Meningococcal disease
 - Salmonellosis
 - Shigellosis
 - *Staphylococcus aureus*, vancomycin-resistant or intermediate resistant
 - *Streptococcus* Group A invasive Disease
 - *Streptococcus* Group B, under 90 days of age
 - *Streptococcus pneumoniae*, invasive
 - Typhoid Fever (*Salmonella* Typhi)

- **Requirement to submit specimens to DHEC’s Bureau of Laboratories:**

The wording “Labs are requested to submit these isolates, positive serologies, or specimens to the DHEC Bureau of Laboratories for confirmatory testing or genotyping” has been revised to “Labs must submit these isolates, positive serologies, or specimens to the DHEC Bureau of Laboratories for confirmatory testing or genotyping.”

Clarifications for Reportable Conditions

- For clarity, the reportable condition “*E. coli*, shiga toxin-producing (STEC), including *E. coli* O157:H7” has been revised to “*Escherichia coli*, Shiga toxin-producing (STEC).”
- Hemolytic uremic syndrome (HUS) has been changed to Hemolytic uremic syndrome (HUS), post-diarrheal. Cases of HUS that do not occur after a diarrheal illness are not reportable to DHEC.

Reporting Reminders

1. What to Report

For all suspected and confirmed cases, report the following (bolded information is new or revised):

- Patient’s name
- Patient’s complete address, phone number, county, date of birth, race, sex, and **last FIVE digits of their social security number**
- Physician’s name and phone number
- Name, institution, and phone number of person reporting
- Disease or condition
- Date of diagnosis
- Symptoms
- Date of onset of symptoms
- Lab results, specimen site, collection date
- If female, pregnancy status
- Patient status: In childcare, food-handler, health care worker, childcare worker, nursing home, prisoner/detainee, and travel in last 4 weeks

2. How to Report

This section’s layout was updated to clarify where specific conditions should be reported.

- **HIV, AIDS, and STD reports** are called in (1-800-277-0873) or mailed to the Division of Surveillance and Technical Support.

- **Lead test results** are mailed to the Division of Children’s Health.
- **TB results** are called in to the TB Control Division (803-898-0558).
- **Routinely reportable diseases** other than HIV/AIDS/STDs, Lead, or TB should be faxed or mailed to your Regional DHEC Office. Mailing addresses and fax numbers are provided.
- Daytime and night/weekend/holiday phone numbers are provided. **Urgently and immediately reportable conditions must be called in to DHEC’s Regional Epi Offices.**
 - Low Country: (843) 441-1091
 - Midlands: (888) 801-1046
 - Pee Dee: (843) 915-8845
 - Upstate: (866) 298-4442

2015 Disease Reporting Form

A few edits were made to the 2015 DHEC Disease Reporting Form (the 1129 card) to assure accurate reporting.

- **Dates**
 - Under Laboratory Information, “Report Date” has been changed to “Result Date”.
 - “Date Reported to Health Department” has been dropped. This has been replaced with “Today’s Date” which is now at the top of the form.
- **Reporter Information**
 - “Responsible Physician Name” has been changed to “Ordering Physician Name.” This will assist DHEC with follow up investigations regarding testing ordered by a provider who did not retain primary responsibility for the care of the patient.
 - Reporting Facility Address has been added.
- **Patient Identifying Information**
 - Reporters are asked to provide the last FIVE (not six) digits of the patient’s social Security Number.
- **Other**
 - The items in the “DHEC Use Only” fields were deleted.

The Disease Reporting Forms are available from the DHEC website at www.scdhec.gov/library/D-1129.pdf.

Links for Disease Reporting Information

Reportable Diseases Page on DHEC website

- www.scdhec.gov/Health/FHPPF/ReportDiseasesAdverseEvents/ReportableConditionsInSC

PDF List of Reportable Conditions

- www.scdhec.gov/library/CR-009025.pdf
- Includes contact numbers for daytime and after-hours disease reporting

PDF Laboratory List of Reportable Conditions

- www.scdhec.gov/library/CR-009036.pdf

SC DHEC Disease Reporting Form

- www.scdhec.gov/library/D-1129.pdf

Questions?

For questions about Disease Reporting or to discuss electronic disease reporting via DHEC’s electronic disease surveillance reporting system, call the DHEC Bureau of Disease Control in Columbia: 803-898-0861 (M-F 8:30 AM to 5 PM).

Flu Seasons are Unpredictable: A Look Back at Influenza Activity and What Providers Need to Know Today

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Heightened interest in flu activity begins in the fall of each year and public health officials are typically asked to speculate about what the winter will bring based on a “typical flu season”. This look back at surveillance data from recent flu seasons explains that while some prediction is possible, there really is no such thing as a typical flu season. Contributors to variation in flu activity and severity in populations include: the dominant circulating strains, how well matched available vaccine is to circulating strains, genetic changes in flu viruses, vaccination coverage rates and even the age and health of vaccinated individuals.

Scientists analyze the antigenic characteristics of circulating flu strains each year to determine the composition of flu vaccines for various parts of the world; influenza viruses change constantly thus the need for annual flu vaccination. Influenza type A viruses change in two ways. Antigenic drift results in small, gradual genetic changes that produce different but closely related influenza type A strains. Antigenic shift is an abrupt, major change in an influenza type

A virus resulting in entirely new hemagglutinin (HA) or neuraminidase virus coat proteins. Antigenic drift occurs continually, while antigenic shift is uncommon, creating novel strains that may cause pandemics. Influenza type B viruses change only by more gradual antigenic drift.

Table 1 reviews selected characteristics of recent flu seasons and data from the 2014-2015 flu season to date; each of the seasons are unique. In 2009 the novel H1N1 pandemic strain began circulating and atypical characteristics of a flu season with a novel strain were seen. Flu activity began in the early Spring rather than Fall, and universal susceptibility in the population to a new strain resulted in a moderately severe season as compared to other recent seasons. As compared to some historical pandemics, however, the 2009 pandemic was relatively mild.

In the 2010-2011 and 2011–2012 flu seasons, H1N1 continued to co-circulate with other strains becoming a seasonal flu strain. H3N2 strains somewhat predictably cause more severe disease. This is shown by hospitalizations and deaths in the 2012–2013 and the current season to date. Excluding the pandemic flu season, peak flu activity ranged from October to March; a second wave occurred in two flu seasons. An average of 1,173 hospitalizations occurred in South Carolina in the previous five flu seasons, with a range of 114 – 1,941. Data for hospitalizations are likely to be underestimates because all cases are not tested to confirm flu or are not coded and reported as flu. An average of 39 deaths occurred in the previous five flu seasons with a range of 1 – 78.

TABLE 1. INFLUENZA SEASON CHARACTERISTICS IN SOUTH CAROLINA 2009–2014

Flu Season	Dominant Strain(s)	Season Peak & ILI Activity*	2nd Wave	Hospitalizations	Deaths
2009–2010	H1N1 (novel pandemic)	Oct–Nov 6%	Yes	1,091	49
2010–2011	H1N1, H3N2, B**	Feb 7%	No	996	20
2011–2012	H3N2, H1N1	Feb–Mar 1%	No	114	1
2012–2013	H3N2	Nov–Dec 6.1%	Yes B strain dominant	1,721	46
2013–2014	H1N1	Dec–Jan 6.8%	No	1,941	78
2014–2015 (to date)	H3N2 (drifted strain)	- 24.5%	-	1,643 (01/08/14)	38 (01/08/14)

*Estimated ILI activity - percent of outpatient visits for ILI reported by sentinel providers above a mean percentage baseline (2%) of ILI during non-influenza weeks. ILI activity is one of several flu surveillance methods. It is highly driven by the number of sentinel providers reporting and may not be representative of true flu activity in the community.

**Co-circulating strains occurred. The dominant strain varied from week to week.

This flu season disease activity began earlier and is more severe so far than in recent years. H3N2 is the predominate strain circulating. Unfortunately, **the predominant H3N2 strain in circulation has genetically drifted from the H3N2 vaccine virus.**

About 68% of the H3N2 viruses tested by CDC this flu season showed a genetic drift from the H3N2 component of the 2014-2015 developed for the Northern Hemisphere quadrivalent and trivalent influenza vaccine (A/Texas/50/2012-like); the vaccine is not well matched to the circulating H3N2 strain. The majority of the drifted viruses are antigenically similar to A/Switzerland/9715293/2013 viruses, the H3N2 component in the 2015 Southern Hemisphere influenza vaccine. The drifted strain was first detected in the United States in early 2014 and has been increasing through the spring and summer. There is a strong likelihood that the drifted viruses will continue to circulate. Clinicians are urged to follow the recommendations for flu prevention. The following are key points that a practitioner needs to know to help protect their patients this flu season:

- How well the flu vaccine prevents flu illness ranges from season to season. Even when the vaccine match is very good, vaccine effectiveness varies across the population, depending on the age and health of the person being vaccinated, when they are vaccinated and even, potentially, which vaccine was used.
- It takes about two weeks for immunity to develop, so offering the vaccine as soon as it becomes available offers protection if flu activity begins early, but vaccine should be offered for as long as flu activity continues.
- The flu vaccine is recommended annually for all people 6 months and older who have not yet received a vaccine. Flu vaccines offer protection against two type A strains and one or two type B strains depending on whether the formulation is trivalent or quadrivalent. A list of all available formulations is found at www.cdc.gov/flu/protect/vaccine/vaccines.htm.

- Although the 2014–2015 Northern Hemisphere vaccine effectiveness against H3N2 disease is not high this year, the 2014-2015 flu vaccine has been found to provide some protection against drifted viruses. This cross-protection reduces disease severity and the likelihood of severe outcomes such as hospitalization and death, especially in high-risk individuals.
- The CDC is re-emphasizing the importance of the use of neuraminidase inhibitor antiviral medications when indicated for treatment and prevention of influenza.
- In patients with severe, complicated, or progressive illness and in hospitalized patients, antiviral treatment might still have some benefits when started after 48 hours of illness onset.
- Encourage good hand hygiene and cough etiquette to your patients.
- Encourage patients to stay home when they are sick to prevent disease spread in the work place and congregate settings like schools.

Seasonal flu vaccine is the most effective way to prevent flu. The flu vaccine not only protects those vaccinated, but high vaccine coverage rates will protect those who are at high risk for serious flu illness but who may have a decreased immune response and, very importantly, infants younger than 6 months old who are too young to get vaccinated are protected.

For additional information about flu guidance for clinicians and flu surveillance and activity in South Carolina, please visit: www.scdhec.gov/flu.

Updates to the School and Childcare Exclusion List for 2015

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NEW Location

School and Childcare Exclusion List and Parent Information

- www.scdhec.gov/Health/FHPPF/SchoolNursesChildcareCenters

For 2015, the School and Childcare Exclusion Lists have been combined into a single list. The Exclusion List now applies to the following groups in out-of-home childcare (as defined in S.C. Code Ann. Section 63-13-20), and in any public, private, parochial, church or Sunday school (SC Reg 61.20):

- Children and employees in out-of-home childcare settings;
- Preschool/kindergarten students in grades 3K, 4K, and 5K;
- Students in grades 1-12; and
- School faculty and staff that have contact with students.

The updated School and Childcare Exclusion List, along with informational brochures for parents of children in school or in out-of-home childcare, is currently available on the DHEC website.

As noted in the box above, the Exclusion List, as well as brochures in English and Spanish for parents, were moved to new locations on the DHEC website. In addition to bookmarking these files for quick access, typing “Exclusion” into the Search box on the DHEC Home Page (www.scdhec.gov) can also help retrieve these files.

Please contact the DHEC Division of Acute Disease Epidemiology (803-898-0861) with any questions about the School and Childcare Exclusion Lists.

Updates to the List for 2015

Record Keeping Update

The requirement to “**maintain a record of students known to have been excluded under this regulation**” has been removed from the document. School or childcare providers may opt to continue keeping these records, as needed.

New Condition Added to the List

Cryptosporidiosis: Exclude students and childcare staff until diarrhea resolves for at least 24 hours. Exclude children with Cryptosporidiosis from recreational water activities (pools, splash pads, water tables, etc.) until 2 weeks after diarrheal symptoms resolve.

Conditions Removed from the List

- **Cytomegalovirus**
- **Infectious Mononucleosis**

While students with these infections are often kept out of school when there is a risk of organ damage from play, these conditions are not easily spread in the school setting. Students with these conditions may attend school if they are well enough to participate in routine activities.

Sports and PE restrictions may apply to students with these conditions.

Exclusion Criteria Clarified or Updated

- **Conjunctivitis:** Exclusion for conjunctivitis is appropriate when staff or students also have fever, severe eye pain, or are too sick to participate in routine school activities. Encourage persons with pinkeye to wash hands frequently and to keep hands away from eyes.
- **Diarrhea:** While most children and staff with diarrhea may return to school once symptoms are resolved for 24 hours, additional criteria apply for children with diarrhea caused by *E. coli*, *Salmonella* Typhi, or *shigella*. Refer to the specific details for each of these conditions in the list.

Changes in Return Criteria

- **Pertussis:** During an outbreak, contacts with cough illness – who are suspected of also being pertussis cases -- may return after 5 days of appropriate antibiotics, after 21 days since last contact with an infected person, after a negative pertussis test, or **(NEW) after a health care provider clears the child or staff member to return to school or childcare.**
- **Shigella in the childcare setting or in kindergarten: 1 negative stool culture is required (rather than 2).**

Children or staff in out-of-home childcare or students in any level of kindergarten may return to school or childcare 24 hours after diarrhea has ceased and at least 1 stool culture is negative for *shigella*. If a child received antibiotics for the *shigella* infection, stool cultures must be collected at least 48 hours after cessation of antibiotics.

A health care professional must clear children or staff in out-of-home childcare or children in kindergarten for readmission for all cases of shigellosis.

Due to the severity of this illness, in an outbreak, DHEC may change the readmission criteria for children and staff with shigellosis.

- **Shigella in the School Setting: Shortened Exclusion Period and Removal of Testing Requirement for Staff and for Most Students**

School-age students who have been diagnosed with *shigella*, who have good hand hygiene and the ability to self-toilet may return to school after diarrhea has stopped for at least 24 hours.

Due to the low infectious dose required to spread *shigella* infection, a student with questionable or poor hand hygiene may be required to have at least 1 shigella-negative stool culture and to be diarrhea-free for at least 24 hours prior to returning. If the child received antibiotics for his or her *shigella* infection, any required cultures must be collected at least 48 hours after cessation of antibiotics.

School staff with *shigella* infection are excluded until diarrhea has stopped for at least 24 hours.

Due to the severity of this illness, in an outbreak, DHEC may change the readmission criteria for students and staff with shigellosis.

Required Laboratory Reporting of *Clostridium difficile* Infections (CDI)

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Clostridium difficile infection (CDI) has been added to the 2015 South Carolina List of Reportable Conditions for laboratory reporting only. All (inpatient and outpatient) *Clostridium difficile* laboratory identifications must be submitted to DHEC through one of the following mechanisms:

- Manual data entry into the Carolinas Health Electronic Surveillance System (CHES);
- Disease report card sent to DHEC with an attached laboratory report, or

- Electronic laboratory report (ELR).

Report positive test results for *Clostridium difficile* toxin detected in stool and the detection method e.g. enzyme immunoassay, nucleic acid amplification test, or toxigenic culture conducted by the reporting laboratory.

While infection prevention efforts have reduced many types of health care-associated infections (HAIs), national data indicate that rates of health care-associated *Clostridium difficile* not only remain high, but also have more than doubled since the year 2000. Those most at risk for CDI are persons (especially older adults) who take antibiotics and also get medical care. When a person takes antibiotics, beneficial intestinal bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *C. difficile* picked up from contaminated surfaces or spread from a health care provider's hands. About 25% of CDIs are identified in individuals first showing symptoms while hospitalized; 75% first show in nursing home patients or in people recently cared for in doctors' offices and clinics.

Laboratories that report through manual data entry into CHES or disease report cards must provide the following information for each CDI lab report:

1. Patient's name
2. Date of birth
3. Patient ID number: last 5 of SSN, if possible, or hospital billing number
4. Sex
5. Date of collection of stool
6. Date of positive test result
7. Name of laboratory performing the test
8. Name of hospital/medical office or health care institution where the stool specimen was collected

Outbreaks of Health Care Associated CDI:

Outbreaks of CDI in health care facilities must be immediately reported to DHEC by the facility. Reports are made to DHEC's Regional Epidemiology Office for the county listed on the annual List of Reportable Conditions.

Meaningful Use

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What is Meaningful Use?

Meaningful Use (MU) uses certified electronic health record (EHR) technology designed to improve health care quality, safety, efficiency, and reduce health disparities; to engage patients and families in their health care; to improve care coordination; and to improve population and public health — all while maintaining privacy and security. MU promotes the adoption of EHR technology by the health care community (health care organizations, doctors' offices, etc). Using EHR technology for syndromic surveillance data, electronic lab result reports (ELRs), and immunization registries enhances DHEC's ability to conduct disease surveillance and respond to public health threats. DHEC is implementing MU and conducting a methodical process for all health care organizations requesting to submit requested data.

MU Requirements

MU establishes specific requirements for eligible professionals (EPs) and eligible hospitals (EH) that must be achieved to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

The requirements differ based on the type of provider (EP vs. EH) and their attestation stage. The table below details the public objectives by provider and stage.

For additional information, visit:

- www.scdhec.gov/Health/FHPF/MeaningfulUse/RecordIncentive
- www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PublicHealthRegistry_Tipsheet-.pdf

Submit questions regarding meaningful use to muhelpdesk@dhec.sc.gov.

Meningococcal Vaccine Update: New Vaccine for Serogroup B

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On Oct 29, 2014, the first serogroup B meningococcal (MenB) vaccine, Trumenba®, was licensed in the United State by the Food and Drug Administration. The vaccine is licensed as a three-dose vaccine series for individuals between 10 and 25 years of age. Additional MenB vaccines are anticipated to receive licensure by early 2015. Prior to the licensing of Trumenba®, existing meningococcal vaccines provided protection against meningococcal serogroups A, C, W, and Y.

According to the Centers for Disease Control and Prevention, about 500 total cases of meningococcal disease were reported in the United States in 2012; of those cases, 160 were caused by serogroup B. While meningococcal disease caused by serogroup B may not be highly prevalent, the disease can result in devastating sequellae and can even be fatal. Several recent outbreaks of MenB disease have occurred on college campuses. Most recently in 2013, two universities in New Jersey and California experienced outbreaks with a combined 13 cases and one death reported.

There are currently no recommendations for routine MenB vaccination. In February 2015, the Advisory Committee on Immunization Practices (ACIP) plans to discuss and vote on recommendations for the use of MenB vaccines in high-risk groups, including those with high-risk medical conditions, microbiologists with occupational exposure, and use in outbreak response. The review of evidence for recommending routine vaccination for expanded groups is set to take place during the June and October 2015 meetings.

Suspect cases of invasive meningococcal disease are immediately reportable to DHEC, regardless of serogroup. For immediately and urgently reportable conditions, call your regional DHEC office (contact information is available on page 11).

TABLE 2. MEANINGFUL USE REQUIREMENTS FOR ELIGIBLE PROFESSIONALS AND ELIGIBLE HOSPITALS

Public Health Objective	STAGE 1		STAGE 2	
	Eligible Providers	Eligible Hospitals	Eligible Providers	Eligible Hospitals
Immunization Registries	Optional	Optional	Required	Required
Electronic Lab Reporting (ELR)	N/A	Optional	N/A	Required
Syndromic Surveillance	Optional	Optional	Optional	Required
Cancer Reporting	N/A	N/A	Optional	N/A
Reporting to Specialized Disease Registry	N/A	N/A	Optional	N/A

Prevention of Congenital Syphilis Infection

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The CDC recommends that effective prevention and detection of congenital syphilis depends on the identification of syphilis in pregnant women, including routine serologic screening of pregnant women during the first prenatal visit, at 28 weeks gestation and at delivery. All women who have a positive syphilis serology and are pregnant must be reported to DHEC.

DHEC's Congenital Syphilis Case Management

DHEC Maternal/Child Health Nurses designated in each public health region will encourage treatment and medical management for prenatal, postpartum, and infant patients with reactive syphilis serology. Medical follow-up and/or treatment and evaluation of serological response will be evaluated.

Management of infants born to syphilis positive women:

- All seroreactive infants will receive follow-up examinations and/or serologic testing by their primary care provider every 2-3 months until the nontreponemal test becomes nonreactive. Nontreponemal antibody titers should decline by age 3 months and should be nonreactive by age 6 months if the infant is not infected.
- The DHEC maternal/child health nurse will establish contact with the mother of the infant.
- The DHEC maternal/child health nurse will perform follow-up for mother and infant to include monitoring visits kept with medical provider and treatment initiated or completed.
- The DHEC maternal/child health nurse will work with the mother and infant's primary care provider to ensure all necessary lab work, exams, and/or procedures are completed according to current CDC recommendations based on the case classification.

Please contact DHEC's Division of STD/HIV at (803) 898-0749 with any questions.

Prevention of Perinatal Hepatitis B Infection

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Division of Immunization

The CDC recommends that all pregnant women be tested routinely for hepatitis B surface antigen (HBsAg) during each pregnancy. HBsAg-positive test results, along with mother's pregnancy status, are reportable to DHEC.

DHEC's Perinatal Hepatitis B Case Management

The DHEC Perinatal Hepatitis B Prevention Program provides case management for infants born to HBsAg-positive mothers. Case managers collaborate with prenatal care providers, delivery hospital staff, pediatric care providers, and families to ensure that infants receive recommended post-exposure prophylaxis and post-vaccination serologic testing.

Management of infants born to HBsAg-positive women

- Administer single antigen Hepatitis B vaccine and Hepatitis B Immune Globulin (HBIG) (0.5 mL) within 12 hours of birth
- Complete the vaccine series according to the recommended schedule for infants born to HBsAg-positive mothers
- Ensure a referral to public health (Perinatal Hepatitis B Case Management).
- Conduct post-vaccination serologic testing for anti-HBs and HBsAg after completion of the vaccine series, at age 9-18 months.

For any questions contact DHEC's Perinatal Hepatitis Prevention Program at 803-898-0712.

Epi Notes, DHEC's epidemiology publication, is published in an internet & email-only format.

Continue to receive our updates:

- To subscribe to the Epi Notes for email delivery, send an email to EpiNotes@dhec.sc.gov with "Subscribe" in the subject line.
- Epi Notes is also available from the DHEC website: www.scdhec.gov/Health/DiseasesandConditions/ChronicDiseaseData/EPINotes

Contact the Bureau of Disease Control

Virginie Daguise, PhD, Director
803-898-0713

Linda Bell, MD, State Epidemiologist
803-898-0861

Bureau of Disease Control Divisions

Division of Acute Disease Epidemiology
803-898-0861

Division of Immunization and Prevention
1-800-277-4687

Division of STD/HIV
803-898-0749

Division of Surveillance and Technical Support
803-898-0749

Division of Tuberculosis Control
803-898-0558

DHEC Bureau of Disease Control
2100 Bull Street
Columbia, SC 29201
www.scdhec.gov
803-898-0558

If you are a health professional interested in receiving health notifications from the South Carolina Health Alert Network, please email
CHAN@dhec.sc.gov

Disease Reporting

For immediately and urgently reportable conditions, call your regional health department:

- Low Country: 843-441-1091
- Midlands: 888-801-1046
- Pee Dee: 843-915-8845
- Upstate: 866-298-4442
- DHEC Bureau of Disease Control: 803-898-0861
After-hours: 800-847-0902

Routine reports may be phoned in to your regional health department or faxed/mailed on a completed 2015 South Carolina Department of Health and Environmental Control Disease Reporting Form: www.scdhec.gov/library/D-1129.pdf

Contact information including mailing addresses and fax numbers are found on the List of Reportable Conditions: www.scdhec.gov/library/CR-009025.pdf



FLU WATCH

Flu season has arrived. Be sure to check DHEC's weekly Flu Watch for updates on influenza activity in South Carolina.

- Type "Flu in SC" in the search box on DHEC's home page, or
- Bookmark DHEC's 2013-2014 Flu in South Carolina page in your browser:
www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/Flu/FluData

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